No. 19-36020

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN DOE #1, et al.,

Plaintiffs-Appellees,

v.

DONALD TRUMP, in his official capacity as President of the United States, et al.,

Defendants-Appellants.

On appeal from the United States District Court

for the District of Oregon,

Case No 3:19-cv-01743-SB, Hon. Michael H. Simon

***AMICI CURIAE* BRIEF OF 38 HEALTH POLICY EXPERTS IN SUPPORT OF PLAINTIFFS-APPELLEES**

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

STATEMENT OF INTEREST OF *AMICI CURIAE*

The *amici curiae* health policy experts are a group of 38 distinguished professors and researchers from the disciplines of economics, public health, health policy, and law, listed in the Appendix, who are experts with respect to the economic and social forces operating in the health care and health insurance markets.[1] *Amici* have closely followed the development, adoption, and implementation of the Affordable Care Act (ACA), Medicaid, and the Children's Health Insurance Program (CHIP). They are familiar with the structure of these programs and the defects in our health care system these programs were enacted to remedy. They are knowledgeable as to the risks and limitations of non-ACA compliant health insurance plans and of relying on one's own resources rather than purchasing insurance. Finally, they are well-informed regarding the nature and causes of health care provider uncompensated care.

Amici submit this brief to assist this Court in assessing the district court's conclusion that plaintiffs' challenge to the Presidential Proclamation requiring certain immigrants to either purchase specific kinds of

[1] *Amici* affirms that no counsel for any party authored this brief in whole or in part; no party or party's counsel contributed money to fund preparation or submission of the brief; and no one contributed money to fund the preparation or submission of this brief. Further, all parties consent to the 38 health policy experts submitting this timely amicus brief.

unsubsidized health insurance or otherwise have resources to pay for foreseeable medical expenses is likely to succeed on the merits, that the plaintiffs are likely to suffer irreparable harm if preliminary relief is not granted, and that the balance of the equities and the public interest weigh in favor of a preliminary injunction. We ask this court to affirm the district court's decision.

STATEMENT OF CASE AND SUMMARY OF ARGUMENT

On October 4, 2019, President Donald Trump issued a Proclamation entitled "Presidential Proclamation on the Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System." (Proclamation No. 9945, 84 Fed. Reg. 53991 (Oct. 4, 2019).) The Proclamation asserts (but does not provide evidence) that legal immigrants are a significant cause of health care providers incurring $35 billion a year in uncompensated care costs and increases in taxpayers' costs. *Id*. The Proclamation declares that:

> An alien will financially burden the United States healthcare system unless the alien will be covered by approved health insurance, as defined in subsection (b) of this section, within 30 days of the alien's entry into the United States, or unless the alien possesses the financial resources to pay for reasonably foreseeable medical costs.

Id. at 53992.

Reducing uncompensated care is the primary stated goal of the Proclamation. In an attempt to achieve this goal, the Proclamation suspends and limits visas to immigrants who do not fit into specific exempted categories unless the immigrant purchases certain specified kinds of health insurance or proves financial capacity to meet "reasonably foreseeable medical costs" to a consular official. *Id.*

Importantly, by requiring immigrants to purchase these specific kinds of insurance, the Proclamation steers immigrants away from other kinds of coverage that would be more effective in reducing uncompensated care.

On October 30, 2019, seven individuals and a nonprofit organization affected by the Proclamation filed a complaint in the United States District Court for the District of Oregon seeking to enjoin the Proclamation's enforcement. *Doe et al. v. Trump et al.*, No. 3:19-cv-01743-SI (D. Or.). On November 1, 2019, the plaintiffs moved U.S. District Court Judge Michael A. Simon for a temporary restraining order, which he granted the next day. *Doe et al. v. Trump et al.*, No. 3:19-cv-01743-SI (D. Or.) at Docket Entry No. ("Dkt.") 7; *see also* Dkt. 8. On November 8, 2019, plaintiffs moved for class certification and a preliminary injunction. Dkt. 44; Dkt. 46. The District Court granted a nationwide preliminary injunction on November 26, 2019. Dkt. 95. The Department of Justice, on behalf of the defendants, appealed

that decision to this Court on December 4. Dkt. 104, *appeal docketed*, No. 19-36020 (9th Cir. Dec. 4, 2019). This brief is offered in support of the preliminary injunction.

The Proclamation challenged in this case subverts the ways federal law attempts to reduce providers' exposure to uncompensated care. It would be expected to increase rather than decrease the rate at which recently arrived immigrants require uncompensated care because it steers individuals away from the types of comprehensive coverage that are most effective in preventing uncompensated care. It also discriminates against immigrants with low or moderate incomes by disallowing an immigrant from showing compliance with the Proclamation by acquiring the forms of coverage designed for those with limited resources: Medicaid, CHIP, or Affordable Care Act premium tax credit subsidized coverage. Further, it discriminates against those with preexisting conditions by encouraging the purchase of forms of insurance that are medically underwritten and exclude preexisting condition coverage, in direct contravention of the intent and structure of federal health care coverage policy.

ARGUMENT

I. A variety of federal statutes complement one another to reduce providers' exposure to uncompensated care by ensuring coverage is affordable, by protecting individuals with preexisting conditions, and by providing comprehensive coverage for all U.S. residents.

The term "uncompensated care" refers to health care services that are delivered by a provider for which the health care provider is not reimbursed. It includes cases where the provider agrees (either before or after providing the service) that it will not collect payment for the service, and cases where the provider bills someone—usually the patient—for all or part of the care but the bill is never paid.[2] Uncompensated care sometimes arises because a person is uninsured, but it can also arise when a patient has insurance and the insurance does not cover the relevant costs. This latter situation, called underinsurance, causes uncompensated care when insurance completely excludes a particular service from a patient's benefit package or imposes significant cost-sharing that requires the patient rather than the insurance company to pay a large fraction of the costs.

Three federal programs—Medicaid, the Children's Health Insurance Program, and the Affordable Care Act—work together to help ensure that all

[2] *Uncompensated Hospital Care Cost Fact Sheet – January 2019*, American Hospital Association (2019), https://www.aha.org/factsheet/2019-01-02-uncompensated-hospital-care-cost-fact-sheet-january-2019 (last visited Jan. 31, 2020).

U.S. citizens and lawfully present immigrants can obtain adequate health coverage and, therefore, that they need not impose uncompensated care costs on health care providers. The core strategy in all of these programs is to provide access to coverage (1) at an affordable price, (2) in a way that will not discriminate against individuals with preexisting conditions, (3) while covering a wide array of health services.

A. Federal coverage programs promote affordability, non-discrimination, and comprehensiveness.

Federal coverage programs are designed to provide affordable options for people of varying incomes. Medicaid and CHIP offer coverage for the lowest income residents and coverage is generally available with no or only nominal premiums and cost-sharing, with the maximum permissible family financial responsibility increasing as family income rises. 42 C.F.R. § 447.56. The ACA offers subsidized private coverage to a wide swath of moderate-income consumers who are not eligible for coverage in Medicaid or CHIP or from an employer.[3] Households' responsibility for premiums and cost-sharing in ACA coverage similarly increases with family income. 26 U.S.C. § 36B; 42 U.S.C. § 18071. For consumers enrolling in ACA coverage using the

[3] *Overview of the Affordable Care Act and Medicaid*, Medicaid and CHIP Payment and Access Commission, https://www.macpac.gov/subtopic/overview-of-the-affordable-care-act-and-medicaid (last visited Jan. 31, 2020).

technology platform operated by the federal government, the federal government on average covered 87% of the cost of coverage among those who qualified for financial assistance in 2019.[4]

Similarly, in all three of these programs, benefits must be provided without regard to an individual's preexisting health conditions. 42 U.S.C. § 1396(a)(8); 42 U.S.C. § 300gg-4. Thus, individuals with demonstrated health care needs are not excluded from these programs.

In addition, these programs all feature a comprehensive benefit package that covers a wide array of services that enrollees are likely to need. Medicaid's required benefit package for adults includes a core set of benefits like hospitalization, outpatient care, and emergency services, 42 U.S.C. § 1396(d), and children are guaranteed an even wider set of benefits. 42 U.S.C. §1396d(r). Similarly, private coverage under the ACA must cover ten "essential health benefits" that encompass a full range of health care services. 42 U.S.C. § 18022(b); 42 U.S.C. § 300gg-6.

[4] *Health Insurance Exchanges 2019 Open Enrollment Report*, CMS.gov (March 25, 2019), https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2019-open-enrollment-report (last visited Jan. 31, 2020).

B. Affordability, non-discrimination, and comprehensiveness are essential strategies to avoid uncompensated care.

Affordability at all incomes, non-discrimination based on health status, and a comprehensive benefit package are essential features to effectively ensure access to health coverage, and therefore essential to provide insurance coverage for a large share of expected medical costs and prevent uncompensated care.

Health care is expensive: the average family insurance plan offered by employers cost more than $20,000 in 2019.[5] If not subsidized in some way, this cost would be entirely out-of-reach for a large fraction of families; this average cost of a typical employer health insurance plan represents nearly one-third of U.S. median income.[6] Employer coverage is the most popular form of coverage in the United States with costs shared between employers and employees,[7] but it is somewhat more expensive than other forms of

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[5] *2019 Employer Health Benefits Survey*, Kaiser Family Foundation (Sept. 25, 2019), https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/ (last visited Jan. 31, 2020).

[6] Gloria G. Guzman, *Household Income: 2018*, United States Census Bureau (Sept. 26, 2019), https://www.census.gov/library/publications/2019/acs/acsbr18-01.html (last visited Jan. 31, 2020).

[7] *Health Insurance Coverage of the Total Population Timeframe: 2018*, Kaiser Family Foundation, https://www.kff.org/other/state-indicator/total-population (last visited Jan. 31, 2020).

coverage. However, even relatively low-cost Medicaid coverage still costs an average of about $4,000 per (non-disabled) adult and $2,600 per child, or 21% of median household income for coverage of two adults and two children.[8] Without federal coverage subsidy programs, the fraction of U.S. households with insurance coverage would be considerably lower.

Further, health care costs are heavily skewed, with some individuals incurring costs significantly higher than average: just 5% of the population accounts for 50% of health care spending.[9] Therefore, to ensure that health coverage can reach the people most likely to need health care services, insurance needs to be available to everyone regardless of health status. Similarly, the comprehensiveness of coverage is critical to guarding against uncompensated care because individuals often cannot predict what forms of health care they will need. Comprehensiveness standards ensure that when an individual obtains coverage that coverage will pay claims for all types of interactions with the health care system.

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[8] *Medicaid Spending Per Full-Benefit Enrollee Timeframe: FY2014*, Kaiser Family Foundation, https://www.kff.org/medicaid/state-indicator/medicaid-spending-per-full-benefit-enrollee (last visited Jan. 31, 2020).

[9] Bradley Sawyer and Gary Claxton, *How do health expenditures vary across the population?* Kaiser Family Foundation (Jan. 16, 2019), https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population (last visited Jan. 31, 2020).

C. U.S. law expressly makes affordable, non-discriminatory, comprehensive coverage available to immigrants.

Congress has expressly addressed the circumstances under which immigrants, including those who have recently arrived, should be eligible for these coverage programs. While lawfully present immigrants who have been in the U.S. for less than five years are not eligible for coverage on the exact terms as others, all legal immigrants are, crucially, eligible for some form of affordable, subsidized coverage.[10]

Reforms enacted in 2009 enable states to provide Medicaid and CHIP coverage to recently arrived pregnant woman and children and young adults under the age of 21, 42 § U.S.C. 1396(v)(4)(A); 1397gg(e)(1)(N), and 39 states and territories have done so to date.[11] Medicaid coverage is therefore available to some recently arrived immigrants, though it is somewhat less available to this group than to others with comparable incomes.

However, the Affordable Care Act ensures that recently arrived legal immigrants at all income levels—even incomes that are otherwise too low to

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[10] *Coverage for lawfully present immigrants*. HealthCare.gov, https://www.healthcare.gov/immigrants/lawfully-present-immigrants/ (last visited Jan. 31, 2020).

[11] *Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Women*, Medicaid.gov, https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-women (last visited Jan. 31, 2020).

qualify for ACA financial assistance—can receive subsidized ACA coverage if they do not qualify for Medicaid. 26 U.S.C. § 36B(c)(1)(B). That is, Congress explicitly plugged the gap in Medicaid coverage that would otherwise limit coverage for some immigrants. In this way, Congress has ensured that all recently arrived immigrants have access to affordable, non-discriminatory, comprehensive coverage. The Proclamation's claim that immigrants "strain Federal and State government budgets through their reliance on publicly funded programs" is thus misplaced, as Congress has explicitly decided to make those programs available to immigrants. *See* Proclamation No. 9945, 84 Fed. Reg. 53991 (Oct. 4, 2019).

II. The approach taken in existing law has been effective in reducing uncompensated care burdens.

A. Existing programs have increased coverage and reduced uncompensated care.

The approach that the United States has taken to expanding access to health care—offering public or publicly subsidized insurance to those who cannot afford private coverage unassisted and requiring insurers to cover individuals with preexisting conditions for a comprehensive variety of health care services—has dramatically expanded health insurance coverage. In 1965, before Medicare and Medicaid were passed, 30% of the population had no insurance for hospital care and few had coverage for out-of-hospital or

primary care.[12] At the time the ACA was adopted, 46.5 million non-elderly Americans, 17.8% of the population, still lacked health coverage.[13] By 2016, the ACA had driven the number of uninsured and uninsurance rates down dramatically, to 26.7 million and 10%.[14] Gaps in coverage also became shorter and access to health care improved.[15] The available empirical evidence underscores that Medicaid expansion has played a particularly important role in reducing the uninsured rate.[16]

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[12] Rosemary A. Stevens. *Health Care in the Early 1960s*, 18 Health Care Financing Review 11 (1996).

[13] Jennifer Tolbert, Kendal Orgera, Natalie Singer and Anthony Damico. *Key Facts about the Uninsured Population*, Kaiser Family Foundation (Dec. 13, 2019), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ (last visited Jan. 31, 2020).

[14] *Id*.

[15] Herman K. Bhupal, Sara R. Collins, and Michelle M. Doty, *Health Insurance Coverage Eight Years After the ACA*: *Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured*, The Commonwealth Fund (Feb. 7, 2019), https:// www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca (last visited Jan. 31, 2020); *see also* Anais Borja, Sherry A. Glied, and Stephanie Ma. *Effect of the Affordable Care Act on Health Care Access*, The Commonwealth Fund, (May 8, 2017), https:// www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access (last visited Jan. 31, 2020).

[16] Larisa Antonisse, Rachel Garfield, Madeline Guth, and Robin Rudowitz, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, Kaiser Family Foundation (Aug. 15, 2019), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-

As access to coverage increased, provider uncompensated care decreased. Between 2013 and 2015, total hospital charity care and bad debt (the two components of uncompensated care) decreased by $8.6 billion nationwide.[17] In some states, uncompensated care dropped by as much as 63 or 64%.[18] The share of hospital operating expenses consumed by uncompensated care dropped 30% nationally, from 4.4% in 2013 to 3.1% in 2015.[19] States that expanded Medicaid saw particularly dramatic decreases in uncompensated care.[20] Indeed, the drop in uncompensated care was due generally to the strategies described here: expanding subsidized coverage that was comprehensive in scope and covering people with preexisting

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expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/ (last visited Jan. 31, 2020).

[17] *Report to Congress on Medicaid and CHIP*, Medicaid and CHIP Payment and Access Commission, (March 2018), https://www.macpac.gov/wp-content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf (last visited Jan. 31, 2020).

[18] *Id*.

[19] *Id*.

[20] David Dranove, Craig Garthwaite, and Christopher Ody, *The Impact of the ACA's Medicaid Expansion on Hospitals' Uncompensated Care Burden and the Potential Effects of Repeal*, The Commonwealth Fund (May 3, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/may/impact-acas-medicaid-expansion-hospitals-uncompensated-care (last visited Jan. 31, 2020).

conditions, so that vastly more people had an affordable and non-discriminatory path to comprehensive coverage.

III. The Proclamation contravenes the provision Congress has made for immigrants to receive health care and would further increase uncompensated care.

The Proclamation frustrates Congressional action which created a system that ensures immigrants have access to health care and do not burden providers with uncompensated care. As noted above, the programs Congress has created for making coverage available to low- and moderate-income Americans and reducing their cost-sharing—the ACA premium tax credit and cost-sharing reduction programs, Medicaid, and CHIP—have been very successful in reducing uncompensated care, and some form of coverage is expressly made available to all immigrants. The Proclamation blocks immigrants from accessing these programs, and instead drives them to purchase coverage that would leave them underinsured—or uninsured—and increases the problem of uncompensated care. It would, that is, defeat its own purpose.

A. The Proclamation drives immigrants away from the forms of coverage, as provided by Congress, that are best suited to preventing uncompensated care.

The Proclamation lists nine acceptable forms of coverage in which immigrants can enroll. Excluded from the list are the very forms of coverage that Congress has expressly designated as tools to ensure immigrants have

affordable access to insurance: Medicaid, CHIP, and subsidized coverage under the ACA.[21]

As noted above, these programs are especially well suited to preventing uncompensated care, since families' financial responsibility for premiums and cost-sharing scales with income and the programs comprehensively cover health care needs, even for those with preexisting conditions—ensuring that individuals can remain covered, that their deductibles and other cost-sharing obligations will remain relatively affordable, and that their benefit covers their health care needs. And yet, the Proclamation blocks individuals from using these affordable, non-discriminatory, comprehensive sources of coverage to comply with its requirements. Instead, it requires them to obtain some other form of coverage, likely at higher upfront premium costs with greater exposure to cost-sharing. That is, a major impact of the Proclamation is to prevent immigrants from accessing programs—which Congress has expressly made available to them—that make comprehensive, non-discriminatory coverage affordable, an outcome that cannot be rationally related to *reducing* uncompensated care.

[21] *See* 84 Fed. Reg. 157, 41381 (Aug. 14, 2019). Puzzlingly, the Proclamation prevents immigrants from complying with its terms by obtaining subsidized private coverage under the ACA, despite the fact that the Administration has not designated such coverage as a problem in its public charge rule.

B. The Proclamation instead requires immigrants to obtain types of coverage that do not effectively prevent uncompensated care.

Of the nine forms of acceptable coverage listed in the Proclamation, many are unavailable, or unlikely to be available, to immigrants. *See, e.g.* Dkt. 1 at 21; Dkt. 95 (order granting preliminary injunction). Medicare is only available to immigrants who have been in the country for at least five years. Employment coverage would only be available to immigrants who already have a job that provides health insurance at the time they enter the country, and is usually subject to waiting periods which often exceed 30 days and can last as long as 90 days. 42 U.S.C. § 300gg–7. Moreover, many firms do not offer health insurance coverage to employees, particularly small firms and firms with lower-income employees that employ many recent immigrants.[22] Immigrants will generally be ineligible to be enrolled in a family member's coverage unless they are the children or spouse of a person already enrolled in coverage. Tricare is only available to members of the military and their families and survivors.[23]

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[22] Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey*, Insurance Component 2018 Chartbook, Exhibit 1.2 at page 29 (2018), https://meps.ahrq.gov/data_files/publications/cb23/cb23.pdf (last visited Jan. 31, 2020).

[23] Tricare, *Eligibility*, Tricare.mil (last visited Jan. 31, 2020).

That leaves only: unsubsidized individual coverage, short-term plans, visitor's plans, or having sufficient resources to cover "reasonably foreseeable medical costs." *See generally*, Dkt. 1 at 21. These options are either unaffordable, discriminatory, or non-comprehensive, or all of the above, and therefore unlikely to be effective in preventing uncompensated care.

Unsubsidized individual health plans, including catastrophic plans, are expensive and are only available once an immigrant establishes residency in a state, and in any case will often not be available within 30 days of arrival because of rules regarding when coverage becomes effective. *See* Dkt. 61 (Decl. Louise Norris at ¶ 10–11). Catastrophic coverage and unsubsidized individual coverage will not be subject to the cost-sharing reduction provisions of the ACA which dramatically reduce cost-sharing for lower-income enrollees. As a result, the plans will likely have high deductibles, copayments, coinsurance, and out-of-pocket limits that will leave enrollees underinsured compared to the cost-sharing they would face if allowed to purchase the forms of subsidized coverage that Congress has provided. This will, of course, burden health care providers with uncompensated care—defeating the stated purpose of the Proclamation. This is particularly true

of high cost-sharing bronze plans, which have the most affordable premiums.[24]

In fact, the government's own data show that enrollment in coverage among unsubsidized individuals has declined dramatically in recent years because its high cost makes it unaffordable to even moderate-income Americans.[25] Therefore, it is clear that denying access to subsidies—that is, denying a tool, provided by Congress, that makes coverage affordable—is not a policy tool that can be expected to promote coverage and prevent uncompensated care.

As a practical matter, immigrants will most likely purchase short-term plans, visitor coverage, or attempt to prove to consular officials that they can cover "reasonably foreseeable medical costs" from their own resources while remaining uninsured. All of these forms of "coverage" are riddled with discriminatory gaps that leave providers exposed to high uncompensated care costs, especially as compared to the affordable, comprehensive, and

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[24] *The 'Metal' Categories: Bronze, Silver, Gold & Platinum*, HealthCare.Gov (2020), https://www.healthcare.gov/choose-a-plan/plans-categories/ (last visited Jan. 31, 2020).

[25] *Centers for Medicare and Medicaid Services Releases Reports on the Performance of the Exchanges and Individual Health Insurance Market*, (July 2, 2018), https://www.cms.gov/newsroom/press-releases/centers-medicare-and-medicaid-services-releases-reports-performance-exchanges-and-individual-health (last visited Jan. 31, 2020).

non-discriminatory coverage of the ACA, Medicaid, and CHIP, which are excluded by the Proclamation.

Short-term coverage is not subject to the insurance reforms Congress adopted under the ACA and has many serious limitations that render it of little value in protecting immigrants and is likely to leave providers with high volumes of uncompensated care. *See, e.g.*, Dkt. 56 (Decl. Sarah Lueck); Dkt. 57 (Decl. Dania Palanker); *and* Dkt. 64 (Decl. Stacey Pogue). To begin, short-term plans generally do not cover care needed to treat a preexisting condition.[26] (About half of all Americans have preexisting conditions,[27] and immigrants' health status is likely similar.) Some individuals may be turned down by short-term plan insurers based on their prior health status.[28] Others will face benefit exclusions based on prior health care needs; that is, they will be able to purchase a plan, but the plan will expressly exclude a

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[26] *See* Karen Pollitz, Michelle Long, Ashley Semanskee & Rabah Kamal, *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/ (last visited Jan. 31, 2020).

[27] The Center for Consumer Information & Insurance Oversight, *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans*, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/preexisting (last visited Jan. 31, 2020).

[28] Pollitz et al., *supra n.* 26.

particular type of care (like chemotherapy), or care for a specified condition (like cancer), or care for a named organ system (like the lungs).[29] Short-term coverage will, therefore, either be unavailable to many immigrants or of limited use when seeking medical care—excluding the very conditions for which they are likely to need care.

Short-term coverage is also generally subject to other conditions that seriously limit its value. Short-term coverage often exposes enrollees to large amounts of cost-sharing.[30] Some short-term policies, for example, may require cost sharing in excess of $20,000 per person per policy period (compared to the $8,150 limit for ACA-compliant subsidized plans and far lower limits for lower-income enrollees, and very low limits in CHIP Medicaid).[31] Most short-term policies are subject to annual or lifetime dollar limits, including dollar limits on specific services, like a $3,000 limit on prescription drugs, or mental health or substance use disorder treatment

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[29] *Id.*

[30] Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Ctr. On Budget & Pol'y Priorities (Sept. 20, 2018), https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers (last visited Jan. 31, 2020).

[31] *See* Pollitz et al., supra n. 26.

coverage, or a $250,000 limit on total coverage.[32] Some short-term plans also impose limits on the number of services an enrollee can receive (visit limits) or the amount paid per visit (leaving the enrollee subject to balance billing).[33] Many plans commonly completely exclude coverage for entire categories of care for all enrollees.[34] One study of short-term plans found that 43% do not cover mental health needs, 62% do not cover substance use disorder treatment services, 71% do not cover prescription drugs, and 100% do not cover maternity care.[35]

This means that providers who treat an immigrant covered by a short-term policy for any serious medical condition can end up uncompensated for much of the care they provide because of the gaps in affordability and the discriminatory and non-comprehensive nature of these plans. The short-term plan may entirely exclude coverage for the benefit the provider delivered or may exclude an individual from accessing the benefit based on her health history. And even if a service is covered, the provider may be

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[32] *Id.*

[33] *Id.*

[34] *Id.*

[35] *Id.*

required to bill as much as $20,000 in cost-sharing to the consumer and may find that the consumer's benefit "runs out" by hitting an annual limit.

Moreover, short-term coverage only meets the conditions of the Proclamation if it is available for at least 364 days.[36] Short-term coverage is only available in 26 states for this length of time, and is totally prohibited in 8 states.[37] For many immigrants, therefore, 364-day short-term coverage is simply not an option.

"Visitor insurance" poses all the same problems. This form of coverage is generally intended to cover short-term visits by the resident of one country to another country, not for people who are relocating permanently, and therefore has been the subject of far less analysis. *See, e.g.*, Dkt. 31 at 23. It is not subject to ACA regulation and is usually subject to the same limitations as short-term coverage. Dkt. 61 (Decl. Louise Norris at ¶ 4). It will usually not cover preexisting conditions. *Id.* It often does not cover comprehensive

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[36] Health Reform, *ACA Open Enrollment: For Consumers Considering Short-Term Policies*, Kaiser Family Foundation (Oct. 25, 2019), https://www.kff.org/health-reform/fact-sheet/aca-open-enrollment-for-consumers-considering-short-term-policies/ (last visited Jan. 31, 2020).

[37] Justin Giovannelli, JoAnn Volk, and Kevin Lucia, *States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership*, The Commonwealth Fund (Jan. 15, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/states-make-indivldual-coverage-more-affordable-federal-needed (last visited Jan. 31, 2020).

benefits, such as maternity, mental health and substance use disorder treatment, or pharmaceuticals. Dkt. 46 at 18. (Pl.'s. Mot. Prelim. Inj.) It often has high deductibles, out-of-pocket limits, or other cost-sharing, and annual and lifetime limits. That is, it suffers from the same gaps as short-term coverage, and is similarly likely to leave immigrants without coverage for significant medical costs and providers with substantial uncompensated care obligations. Dkt. 56 (Decl. Sarah Lueck at ¶ 11). And even if a new market for visitor coverage were to arise as a result of the Proclamation, there would be no incentive for it to offer more generous or comprehensive coverage compared to short-term plans; if anything, the coverage would be less generous because it is attempting to attract lower-income consumers who would otherwise find subsidized forms of coverage more attractive.

Finally, the Proclamation also allows an immigrant to establish that he "possesses the financial resources to pay for reasonably foreseeable medical costs." Proclamation No. 9945, 84 Fed. Reg. 53991 (Oct. 4, 2019). That is, immigrants can remain uninsured if they convince a consular official that they have sufficient resources on hand. The defendant's procedures for implementing the Proclamation, Admin. R. at 5, 16. (Nov. 21, 2019), further explain:

> In lieu of approved health insurance, the applicant may demonstrate possession of the financial resources to pay for

> reasonably foreseeable medical costs in the United States. [The Proclamation] 9945 does not include a time-bound limitation on how far into the future officers should look when assessing "reasonably foreseeable medical costs," and officers should not engage in unsupported speculation. To assess "reasonably foreseeable medical costs," consular officers should evaluate costs based on an applicant's current medical state as reflected in the medical report by the panel physician. Officers should not speculate on an applicant's potential future health and may only make this determination based on the applicant's current medical state. An officer should consider the applicant's financial resources as well as funds that could be provided by the applicant's sponsor, which can be determined using Form I-864..... To determine if an alien's health will not impose a substantial burden, officers should rely on the medical exam to determine if there are current health issues, including acute or chronic conditions, which will require extensive medical care and likely result in particularly high medical costs. If the applicant has such a condition, officers must determine if the applicant has either health insurance or funds to cover foreseeable medical costs.

This is not a logically sound approach to reducing uncompensated care for a wide variety of reasons. First, many medical expenses are not foreseeable. Many costs, and particularly high costs and emergency costs, are attributable to causes that cannot be foreseen. An automobile accident would be an obvious example. Other costs may be attributable to conditions not readily discovered in an examination by the panel physician, like a new cancer diagnosis or a future pregnancy. But even when a condition is known, like diabetes or COPD, the concept of "reasonably foreseeable" costs for an

individual is incompatible with the way health care resources are actually expended.

This incompatibility is demonstrated by an analysis of spending associated with 43 common conditions. It finds that if all individuals possessed resources equivalent to the average costs of treating someone with their diagnoses and spent those funds on the care they received, more than 50% of the care delivered in a year would still be uncompensated.[38] This is because so much health care spending is associated with a small number of people—in this analysis, 80% of the spending is associated with those who spend more than the average amount for their condition.[39] Further, depending on the condition, between 54% and 83% of people would spend less than the average for their condition, which means many people would be required as a condition for a visa to have far more resources on hand than they would spend, even as much spending remains uncompensated.[40]

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[38] Sherry A. Glied and Benjamin Zhu, *The Unintended Consequence of Requiring Immigrants to Meet "Reasonably Foreseeable" Medical Costs*, The Commonwealth Fund (Jan. 31, 2020), https://www.commonwealthfund.org/blog/2020/immigrants-foreseeable-medical-costs (last visited Jan. 31, 2020).

[39] *Id.*

[40] *Id.*

Notably, this analysis only considers spending in situations where the individual has been previously diagnosed; it does not consider the fact that many conditions will not have been diagnosed when a determination of "reasonably foreseeable" medical costs might be made.[41] That is, even when we know exactly what health conditions an individual has, asking the individual to have resources associated with the average cost for treating those conditions would, on the one hand, still leave a very large uncompensated care burden, and, on the other, bar many people from immigrating who would not cause an uncompensated care burden.

Indeed, across the U.S. system of financing health care, there are many applications where policymakers or other entities want to predict the expected medical costs of an individual. A robust literature and set of methodologies have arisen around this exercise, generally associated with attempts to conduct "risk adjustment" by measuring the relative risk of one patient relative to others.[42] Risk adjustment uses all available information about a person (including their age, sex, and medical information like past

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[41] *Id.*

[42] *See, e.g.*, Issue Brief, *Risk Assessment and Risk Adjustment*, Am. Acad. of Actuaries (May 2010), https://www.actuary.org/sites/default/files/files/publications/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf (last visited Jan. 31, 2020).

diagnoses and prescriptions) and attempts to predict expected medical spending.[43] Some of the most advanced risk adjustment algorithms are operated by the federal government in conjunction with the Medicare program—and yet these complex methodologies are able to explain only 15 to 28% of the variation in medical costs between individuals when operating prospectively.[44] That is, even using the most sophisticated tools available, powered by detailed information from an individual's medical record, only a small fraction of medical spending can be explained by what we know, *i.e.*, is reasonably foreseeable.

And of course, the ability to explain these relatively small fractions of total spending is premised on using complex predictive tools. A consular official with no training in medicine or health economics is unlikely to achieve anything close to even this limited level of success. That is to say, asking consular officials to predict "reasonably foreseeable medical expenses" would be expected to accurately account for something far less than 15% of the variation in medical spending among individuals. This is not a meaningful form of "health coverage."

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[43] *Id.* at 1.

[44] *Id.* at 2.

IV. The Proclamation cannot be expected to reduce the rate at which immigrants generate uncompensated care burdens.

In sum, the Proclamation's claims with respect to uncompensated care are not supportable as a matter of health economics and health policy, or of law. It states that it is intended to reduce uncompensated care costs. Proclamation No. 9945, 84 Fed. Reg. 53991 (Oct. 4, 2019). But in fact, it would drive immigrants to forms of coverage that would increase their exposure to uncovered costs and therefore drive up the uncompensated care burden of providers when treating immigrants. It effectively bars access to subsidized ACA-compliant, Medicaid, and CHIP coverage, which would cover immigrants' medical needs, and which Congress had made available to them. Instead, it forces immigrants to buy short-term coverage, visitor insurance, or higher premium and cost-sharing plans, or to go without coverage after establishing they have the resources to pay "reasonably foreseeable medical costs."

In fact, recent experience demonstrates that the Proclamation's approach would achieve results directly opposite to those it purports to want. Uncompensated care costs declined for several years as the ACA was implemented, as described above, but since 2016 uncompensated care costs

have grown by over $5 billion.[45] Observers believe that uncompensated care is increasingly caused by high cost-sharing and underinsurance, not uninsurance.[46] But the Proclamation would drive immigrants into just these forms of skimpy coverage and would aggravate the uncompensated care problem.

As a simple example, consider a woman who becomes pregnant after entering the United States. If she had enrolled in Medicaid or CHIP coverage, which she would be entitled to in most states and territories if her income was in the appropriate range, she would have complete coverage for labor, delivery, and prenatal care with no or very limited cost-sharing.[47] If she was not able to access Medicaid or CHIP and enrolled in subsidized coverage under the ACA, she would face income-adjusted premiums and

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[45] *Uncompensated Hospital Care Cost*, Am. Hosp. Assoc. (Jan. 6, 2020), https://www.aha.org/factsheet/2019-01-02-uncompensated-hospital-care-cost-fact-sheet-january-2019 (last visited Jan. 31, 2020).

[46] Kaiser Health News, *High-Deductible Plans Jeopardize Financial Health of Patients and Rural Hospitals* (Jan. 10, 2020), https://khn.org/news/high-deductible-plans-jeopardize-financial-health-of-patients-and-rural-hospitals/ (last visited Jan. 31, 2020).

[47] *See Medicaid and CHIP Coverage of Lawfully Residing Children and Pregnant Women*, (Dec. 11, 2019), https://www.medicaid.gov/medicaid/enrollment-strategies/medicaid-and-chip-coverage-lawfully-residing-children-pregnant-women (last visited Jan. 31, 2020).

cost-sharing that would similarly ensure coverage for her pregnancy. *See* Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(b), § 18071; *and* 26 U.S.C. § 36B. But neither form of coverage satisfies the Proclamation. Assuming she cannot afford a full price ACA plan, under the Proclamation she would instead be forced to obtain a short-term plan, a visitor plan, or remain uninsured on the basis of having sufficient resources to pay reasonably foreseeable costs. *None* of these forms of "coverage" would compensate providers for the costs associated with her prenatal care, labor, and delivery: short-term plans universally exclude maternity benefits, visitor's plans are expected to do the same, and the pregnancy would not have been "reasonably foreseeable" at the time of entry. In these situations, the entire maternity event is potentially uncompensated care.[48]

CONCLUSION

The Proclamation bars immigrants from access to forms of coverage that they have a right to under federal law. It discriminates against immigrants with fewer resources or preexisting conditions. In doing so it not only fails to achieve its purpose, but also will exacerbate the problem it claims

[48] In some circumstances, providers may be reimbursed for the costs of labor and delivery by "emergency Medicaid" coverage. 42 U.S.C. § 1396b(v). But this is not a form of coverage; it is a tool to compensate providers after the fact for delivering uncompensated care.

to address. The Proclamation is contrary to law, would impose irreparable harm on the plaintiffs, and is contrary to the public interest. The preliminary injunction order should be affirmed.

Dated: February 6, 2020

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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No. 19-36020

IN THE UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN DOE #1, et al.,

Plaintiffs-Appellees,

v.

DONALD TRUMP, in his official capacity as President of the United States, et al.,

Defendants-Appellants.

On appeal from the United States District Court

for the District of Oregon,

Case No 3:19-cv-01743-SB, Hon. Michael H. Simon

APPENDIX TO *AMICI CURIAE* BRIEF OF 38 HEALTH POLICY EXPERTS IN SUPPORT OF PLAINTIFFS-APPELLEES

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